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The Physician and the Rights of the Unborn

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A reverence for unborn life and a dedication to its preservation are traditions buried deeply in medical philosophy. Exhortations to avoid the dubious solution of abortion are found repeatedly in standards of medical ethics. Prohibitions against direct attacks on unborn life are found, for example, in the Hippocratic oath of the fourth century B.C., the oath of Asaph and Jochanan from the sixth century A.D., the oath of Amatus Luistanus in the sixteenth century, and as late as the Modern Declaration of Geneva in 1948.

There is, at present, a widespread movement to liberalize abortion laws in several states. This movement which originated with the so-called Model Penal Code of the American Law Institute has as its thesis the notion that the reluctance to perform more abortions results from an uncertainty about the present state of the law. Since there are already a considerable number of precedents in case law indicating that physicians are rarely prosecuted or convicted for the performance of abortions under medical indications, it is perhaps naive to think that altering the statute will solve the dilemma. It may very well be that the medical profession's profound regard for the preservation of life may be the true underlying basis for the hesitancy to recommend abortion.

Some suggestion that proponents of changes in abortion laws are aware of this reluctance to accept abortion on a large scale, may be gleaned from the type of vocabulary that is used in their literature. Original proposals that abortion laws be "liberalized" have now been rephrased to suggest that law be "modernized." This alteration suggests that the proponents infer that the medical profession would object at any suggestion of liberalization.

It will be difficult, however, to convince physicians that it is "modern" to perform more abortions. Modern obstetrical practice has reduced not increased, the need for therapeutic abortions. The original editions of Williams' Obstetrics in 1903 and DeLee's Obstetrics in 1913 contained approximately five times as many indications for therapeutic abortions as current editions. Both of these standard textbooks acknowledge this progress. Eastman, in his 1961 edition of Williams' Obstetrics states: "As a result of a sharp and continuing decline in traditional indications, the number of operations performed on these grounds has fallen dramatically over the past two decades with the result that a justifiable interruption of pregnancy is becoming rare." In a similar vein, Greenhill's remarks in the 1965 issue of DeLee's Obstetrics as follow: "Indeed, medical therapy has improved so significantly that it is rare for organic disorders to be aggravated in properly managed pregnancies and, therefore, very few afflictions justify therapeutic interruption of pregnancy, today." In the light of dramatic improvement in obstetrical management, the number of therapeutic abortions should decline, not increase. Considering an estimate of one therapeutic per five hundred live births, Eastman states, "Therapeutic abortion is a greatly abused operation and the incidence of the procedure the country over is much higher than it should be."

Because proponents sense that it will be difficult to make a case for liberalization of abortion laws on therapeutic grounds, the changes are usually posed on humanitarian grounds. The bill proposed before the California legislature by Congressman Anthony Beilenson (A.B. 2310, 1964) is known as the Humane Abortion Act rather than as the Therapeutic Abortion Act, as it was originally proposed. It remains for the individual medical practitioner to judge whether the use of the term "humane" is an apt one where the procedure to which this adjective is applied involves the termination of fetal life in the absence of a threat to maternal life. In any event, any medical practitioner will recognize that his training and competence do not prepare him for the problems involved in being a parent to an infant with congenital anomalies. Since there is no way of knowing whether a fetus in utero is or is not malformed, the question must revolve around the mathematics of risk involved in any individual pregnancy. It must be stated that the risk involved in no presently recognized maternal hazard would support a program of routine therapeutic abortion. In the situation of maternal rubella during the first trimester, for example, no more than 10-20% of infants will be at risk. It is hard to derive a therapeutic principle which would allow the sacrifice of 80-90% normal fetuses in conditions of suspected injury to the fetus as a result of infection or drug ingestion, (2) where pregnancy results from rape or incest, (3) where continuation of the pregnancy would pose a threat to the physical or mental health of the mother. The third category constitutes the greatest potential source of confusion, particularly with regard to what constitutes a threat to mental health. The indication based on malformations of the fetus does fall into the realm of sound medical evidence, however, and the consideration of pregnancy resulting from rape and incest does constitute a valid medical concern even though it is largely in the law-enforcement sphere.

The termination of a pregnancy to avoid the possibility of the birth of a malformed fetus is not truly a therapeutic abortion but a form of euthanasia. The purpose of such a procedure is the mercy killing of a potentially handicapped child over and above any considerations which might relate to the problems involved in being a parent to an infant with congenital anomalies. Since there is no way of knowing whether a fetus in utero is or is not malformed, the question must revolve around the mathematics of risk involved in any individual pregnancy. It must be stated that the risk involved in no presently recognized maternal hazard would support a program of routine therapeutic abortion. In the situation of maternal rubella during the first trimester, for example, no more than 10-20% of infants will be at risk. It is hard to derive a therapeutic principle which would allow the sacrifice of 80-90% normal fetuses in conditions of suspected injury to the fetus as a result of infection or drug ingestion, (2) where pregnancy results from rape or incest, (3) where continuation of the pregnancy would pose a threat to the physical or mental health of the mother. The third category constitutes the greatest potential source of confusion, particularly with regard to what constitutes a threat to mental health. The indication based on malformations of the fetus does fall into the realm of sound medical evidence, however, and the consideration of pregnancy resulting from rape and incest does constitute a valid medical concern even though it is largely in the law-enforcement sphere.

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order to achieve such a limited prophylaxis. Even a figure of 20% abnormalities would have to include remediable cardiac defects, tonal hearing loss, and intraterine growth retardation (which may truly be a reflection of placental rather than fetal infection). When one talks of severe life-blighting congenital anomalies due to rubella, he is talking about blindness due to cataracts or microcephaly with mental retardation. The risk of a fetus suffering one of these catastrophes is much less than 20%. The risk of the child being born with any type of congenital anomaly following maternal rubella is significantly less in any non-epidemic year than it is during a rubella epidemic. Since Mayer and Parkman of the National Institute of Health have already reported on field trials of an apparently potent rubella vaccine, it is likely that a vaccine will be available before the next rubella epidemic occurs. The solution to the rubella dilemma lies in this vaccine and not in therapeutic abortion. Some would suggest that the therapeutic abortion allowance could serve as a stopgap against the time when the vaccine is available. Such laws are easier to pass than repeal, however. The eugenic movement around the turn of the century, for example, led to laws in seventeen states which would prohibit the marriage of epileptics and allow for their sterilization. Now, sixty years later, with all the scientific data upon which such laws were based thoroughly discredited, three states still carry the old eugenic laws on their statute books. Most doctors will be relieved to avoid the necessity of making a decision involving therapeutic abortion for rubella, an enigma among diseases. This diagnosis is extremely difficult on clinical grounds, differential from other exanthematous diseases is often impossible without supporting virological evidence, and historical evidence for immunity is virtually worthless. Even with a firm diagnosis, many physicians will not be sure of the risks. Twenty percent of the therapeutic abortions in Steven's series, for example, were performed during the second trimester when the risk is minimal if present at all. It is small wonder, then, that the medical profession at large has been unwilling to accept abortion as a solution to the rubella dilemma. Until such time as the malformed uterus can be identified in utero, even infanticide, as some have ironically stated, remains a better solution.

The problem of teratogenic drug ingestion would also seem irrelevant in this context. The only drugs which were marketed in the United States which have teratogenicity are the antimetabolites such as folic acid. Alternative non-teratogenic drugs for the treatment of lymphomas are available for use during pregnancy. Thalidomide was not on the American market and it is unlikely that a drug with such a teratogenic capability could pass the studies required by the Food and Drug Administration. Indeed, thalidomide studies on the rat and more recently, on the baboon have produced limb bud anomalies in animal fetuses also identical to the phocomelia seen in humans. The thalidomide tragedy was, in a sense, iatrogenic and, therefore, deserving of the profession's utmost concern and compassion. In keeping with noblest medical tradition is the work of Dr. Gustav Hauberg of the Anna Stift rehabilitation school in Hanover, Germany. In this institution, a team of orthopedists, social workers, and teachers have been engaged in the developing of abilities of thalidomide-damaged children so that, despite their heavy handicaps, they will still value life. Mental and psychological development, has been normal, in most cases, and higher education potential is attributed to many. Thus, even such a poignant situation as the birth of 7,000 phocomelias can have its positive aspect when medical resources are properly mobilized. The best preventative against a recurrence of such a tragedy is the basic reluctance of obstetricians to give any new drugs to pregnant women.

Certainly the entire medical profession, not just abortion-law revisionists, has compassion for victims of forcible rape and incest. Incest is a question, however, as to the true dimensions of this problem. Studies on human fertility would suggest that not too many pregnancies are likely to result from a single act of forcible rape. If pregnancy were to occur, it is questionable whether psychological trauma would be prevented, unaffected, or intensified by therapeutic abortion. Sympathetic inquiry will usually disclose that many pregnancies alleged to be the result of a single act of forcible rape are really the outgrowth of a prolonged cohabitation. If the law is interpreted as allowing abortion in the case of statutory rape, it automatically qualifies any unmarried girl under eighteen years of age, who becomes pregnant.

Incestuous pregnancy is no less a difficult problem. Many such pregnancies are justifiable, and beyond the time when abortion would be possible. Many cases of alleged incest will fail of prosecution because the victim or her mother will shrink from the financial ruin involved in accusing the father or the social ruin involved in convicting a brother.

The situations in which the physical health of the mother would justify the termination of a pregnancy are constantly decreasing with the progress of medical science. We have probably arrived at a point where, when pregnancy and disease coexist, the former has no long-term effect on the latter when good medical supervision is obtained. The operative hazards of therapeutic abortion are as great as the conservation of the pregnancy, in the best of institutions. According to Coggrove, Johns Hopkins Hospital with a ratio of one therapeutic abortion to thirty-five deliveries and Chicago Lying-In Hospital with one therapeutic abortion per 195 deliveries were unable to improve on the maternal mortality of the Margaret Hague Hospital which performed only one abortion per 16,750 deliveries. Such statistics undercut the need for a wholesale increase in therapeutic abortion performance.

Some authors suggest that the statistics concerning psychiatric com-
The psychiatric benefits of a unborn child, for example, or can hold a defendant liable for injuries sustained by her unborn child as a result of an accidental injury or assault. An unborn child may share in an inheritance. A pregnant woman, convicted of a capital offense, may not be executed until after the baby is delivered.9 In a landmark case in 1964 (Fitkin versus Anderson), the Supreme Court of New Jersey affirmed the fact that the unborn child has rights prior to its birth when it ordered the appointment of a guardian for an unborn child for the purpose of procuring a blood transfusion for the mother contrary to her religious scruples. The court stated: “We are satisfied that the unborn child is entitled to the laws protection . . . We have no difficulty in so deciding with respect to the infant child.” The Constitution in the Fifth Amendment provides that no person shall be deprived of life without due process of law. It is certainly a matter of pause for the medical profession to decide whether two doctors in agreement or even an “Abortion Committee” would constitute due process. If litigation on behalf of the aborted fetus seldom occurs it is, as Quay17 suggests, because the natural prosecutor (the child) is dead while its natural guardian (the mother) is the criminal.

There is deep-seated antipathy toward the abortionist in the medical outlook. Medical students usually refer to the least intellectual and most poorly-motivated member of their groups as the “class abortionist” just as the lawyer of low-calling is the “ambulance chaser.” (This caricature is apparently close to accuracy where the M.D. abortionist is concerned.)18 This disdain for the motivation of the abortionist and the regard for abortion as sordid are certainly elements in the profession’s unwillingness to seek unlimited abortion privileges.

There are, however, non-medical groups arrayed against this conservative medical viewpoint. These vocal groups fall basically into two categories: 1. those who want abortion available on demand, 2. those who want the law changed to conform to present practice—legal and illegal. Those who propose abortion on demand have an inordinate confidence in the wisdom inherent in the average woman’s decision to terminate her pregnancy. Of interest in this regard is the experience of Hoek19 in Sweden. She studied the cases of 500 women who had applied for therapeutic abortion and had been turned down. About 75% of these women went to deliver their babies and were happy with them. 25% had illegal abortions and none committed suicide. Whatever other interpretation is given these figures, it is an unavoidable fact that more than 350 human beings survived who would have been denied life through a caprice if their mothers’ decision had been binding on the physician.

The notion that the liberalization of abortion laws will significantly reduce illegal abortions is an empty illusion. In every country where abortion has been made respectable by liberal laws, illegal abortion traffic has increased. In Copenhagen, for example, after20 the Danish laws
were liberalized in 1939, legal abortions rose ten-fold. Illegal abortion, however, rose four-fold during the same period. 90% of women seeking abortions are married and healthy. There will always be women who find it inconvenient to carry a pregnancy through because of a desire to travel, buy a new car, or a desire simply to avoid having more children. There is no evidence of popular sympathy for such women. These women, however, will turn to illegal or self-induced abortion when denied legal recourse. Thus, there is no reliable means of completely removing the medical and social complications of self-induced and criminal abortion as much as we abhor them.

The notion that abortion laws should be changed because they are so often broken is, of course, a non sequitur. Many laws are breached more often but as Mietus states, "One does not deal with crime by discarding the Penal Code."

The medical profession must be prepared to resist any attempts to use medical means to solve what are basically social and economic problems unrelated to medical practice per se. Attempts to use abortion as a method of birth-control and as a solution to population pressures must be evaluated against a background of the many undesirable consequences of such a program as carried out in Japan, Central Europe, and the Scandinavian countries.

**Summary:**

1. Dedication to the preservation of unborn life is a medical tradition existing from the time of Hippocrates down through the 1948 Declaration of Geneva to the present.
2. Movements to liberalize abortion laws based on the Model Penal Code of the American Law Institute have been proposed in several states.
3. The solutions to problems posed by teratogenic infection and drug ingestion will not be found in therapeutic abortion but rather in a rubella vaccine and careful screening of drugs by progeny studies.
4. The dimensions of the problem of pregnancies resulting from rape and incest are not resolved by any change in our abortion laws, short of making abortion available on demand.

**REFERENCES**


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